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ABSTRACT

This lecture to clergymen presents a discussion of childhood bereavement and possible long-term psychological effects. A correlation between the loss of a parent and later-life mental illness is suggested, as well as the need to look closely at children's unique ways of grieving. The clergyman's role in helping bereaved families is emphasized. (SET)

PREVENTIVE OPPORTUNITIES IN CHILDHOOD BEREAVEMENT.

(DEATH OF A PARENT STUDY)

Lecture to the Clergy

April 8, 1964

Dr. Gilbert Kliman

Dr. Kliman: I'm very pleased to have a chance to talk with you, not just to tell you about our work with bereaved children because I feel this is an area in which the clergy have a great deal to teach psychiatrists as well as possibly to learn. I believe that it is more in the direction of teaching psychiatrists. Certainly we in psychiatric and psychologic professions are deeply interested in the behavior of children who lose a parent. We have many reasons for being interested, practical reasons and theoretic reasons and I would like to tell you a few of those reasons. Then I'll describe some of our observations and come back to the point of my belief that you have much to teach us and only possibly a little to learn at this point.

We're very interested in what happens to children when they lose a parent because we observe a time bomb slowly exploding in the lives of children who lose a parent particularly early in their lives. It's only when we look at statistics retrospectively and study adult patients that we can see children who looked quite well apparently who were unnoticed in their ultimate need for help, later become quite seriously ill in adult life one, two, three, four, five decades later. One can learn this only by studying retrospectively the statistics involving admissions to mental hospitals and to psychiatrist's offices and clinics comparing the rate at which the general population avails itself or is required to avail itself of those facilities, comparing that rate with the rate at which people who have lost a parent early in childhood ultimately avail themselves of psychiatric services. Statisticians studying these figures assure us that it is no accident. This is a significant, meaningful, non-random distinction. People who have lost a parent in childhood go to psychiatrist more often, are required to go to psychiatrists more often, go to clinics more often, go to private practitioners, have major mental illnesses, have to be committed to hospitals, have to live in hospitals more. In some diagnostic categories it is probable that the rate is almost double for bereaved people compared with non-bereaved people. I don't pay too much attention to these statistics because I think they can be quite misleading, but indicate a serious problem, the extent of which may be under estimated, possibly over-estimated. I tend more to believe that we are ignoring many instances of life-long depression not severe enough to warrant psychiatric help, but severe enough to markedly impair the functioning, the usefulness of an individual in his family and in his society. The most impressive statistics indicate a connection between severe depression such as suicidal efforts, becoming practically a vegetable, requiring hospitalization, a connection between that sort of depression and a childhood bereavement.

Let's take a look at a group of 250 or so adult depressed patients in Philadelphia who were recently studied and compared with the same number of non-depressed patients. First the psychiatrists in question rated the degree of depression on a scale from one plus to four plus, because you can't really meaningfully apply numbers to such a process. The control group consisted of patients who had illnesses not involving any significant depression, perhaps some hallucination without depression, perhaps some fearfulness. Those who had depression had about two to three times as great a frequency of childhood bereavement as the non-depressed group. Further, there was a more exquisite correlation. Those who had four plus or highest degree of adult depression in the hospital had been bereaved earliest in life. Thus we see an opposite but easily understood relationship. A child losing a mother or father very early suffers a depression (sooner or later)

which is very severe among those whom we are studying. What happens among those we don't study is a different story entirely. We have no reason to assume that people who don't wind up in psychiatric hospitals or offices are the same as people who are in treatment, although one may reasonably assume that. We cannot insist on this similarity but I do want to point out this very suggestive and apparently very serious factor in the production, precipitation or timing of mental illness. It provides a number of preventive opportunities to which I would like to return in a few moments, and which I believe directly concern the clergy.

You may want to know what theoretic issues are of interest. I suppose you are not deeply interested in psychoanalytic theory or developmental theory because I'm sure you have only one lifetime in this go-around and you're not interested in becoming experts on psychoanalytic theory. But perhaps you have had many occasions in which to think over the impact of tragedies upon those people for whom you are the spiritual caretakers. You might from that point of view be interested to think of the effect of a divorce, accident, or in this instance a death upon the personality of a little child. According to psychoanalytic theory, we could make some predictions that when such a serious event occurs particularly if the child is not well equipped by reason of his own endowments or endowments of his family's personalities. The child is poorly equipped to meet a psychologic injury such as the death of a parent. He is liable to be fixated to that stage of development at which the tragedy occurs. So it seems possible to me, at least I would like to study and alert you to the possibility that a child of age three or even more clearly a child of age one, whose life is still concerned with being fed and toileted, and loses a mother at that point, may become fixated to those very primitive activities which now are the main compass of his emotional life. He may from then on tend to be much more concerned than is good for him with matters of being cared for, being fed, being toileted, fighting toilet procedures, fighting people who feed him, pleading to be fed, or in some symbolic way expressing the emotional infantilisms with which the timing of the tragedy has burdened him for the rest of his life. Now I present that from a very stark point of view. I'm sure it will hardly ever be possible in a process so complex as a single person's life in a family to document such an almost absurdly simple process as I have described. Somebody has a trauma and forever after his psychologic life remains clearly oriented to the time in which the trauma occurred. Yet I believe that we should take this seriously, that in many phases of your work you encounter individuals who are fixed at infantile levels of behavior. In the case of the readily identifiable trauma, I hope we as allied professions will have a mutual alertness to this possibility.

As people working with families, you are interested in the ways the various generations within the family interact. A death within a family provides us with an unusual although painful opportunity to see just how poorly equipped many people are, how very much in need of help many people are, to bring each other's needs and responses into good harmony with each other. In my opinion there are few family processes which show such a disharmony. Here I would like to learn from you.

I'd like to displace your interest for just a little bit to the death of President Kennedy because as painful as that was, I believe it is a little easier

to start out by thinking of someone whom few of us knew as a personal friend or family member, but toward whom most of us felt a personal loss. If you will recall the reactions of adults, there were waves of intense grief, high waves of intense grief often with enourmous crests and climaxes of emotion, weeping, wailing, intense preoccupation with nothing but the sad and horrible thing which had happened. Those waves of emotion still persist in many adults. I think as we recollect the death of Kennedy it still stirs a feeling of depression in most adults. However the waves of emotion among children from the very same family (although often particularly among adolescents reaching high amplitude with crests of weeping, sadness and explicit preoccupation with the President,) were by no means so durable even in terms of hours and days, as those of adults. When we looked into the younger children's lives, we found that the 7 year old children have only momentary feelings of conscious sadness. I don't speak now of the long range impact of this horrible breaking through of barriers against homicide at a national level. The immediate phenomenon of weeping for example rarely lasted more than a few seconds at age 7. This is a sharp contrast to the intense and prolonged grief of adults even for this man whom they had by and large not known as a family member. Yet when we looked more closely as Mrs. Kliman and I did, into the immediate reactions of children, patients as well as non-patients, there was quite a bit else going on which I daresay was not so clear among adults. There was a different level of fantasy life, of fearfulness for example which was not well matched and not in good synchrony with the adults. Let's take the 7 year old group who cried for but a few seconds. That group according to their interviews with us on the first day, second, third, fourth, fifth, seventh days following the assassination, was preoccupied with personal fears. Some of them feared the assassin, possibly a nameless maniac, was at large in their own neighborhoods. Before the killing of Oswald, a number of children expressed to me the idea that Oswald might have been in their own house. They heard the rustlings of paper. One boy as he fell asleep felt that the map next to him had moved. Possibly it was due to some vibration in the house that had been set up by the heavy footsteps of this murderer who had taken refuge in the boy's house. The boy, not entirely unmoved by this fantasy, seized a baseball bat and went into the hall to protect himself and his family from the not yet assassinated assassin. Even after Oswald's death this group, whom I will call latency children, persisted in a vaguer but still readily identified fearfulness. We adults are familiar with fears we had in a more intellectual fashion particularly in the first 24 hours. The war in Cuba might erupt, a world holocaust might be precipitated. These fears quickly faded. It would also be quite rare to find an adult who was personally dreading harm from the assassin as these latency children were. I'm not so sure as to what other differences there may have been between children and adults and their reactions to the Kennedy death. We noticed a few thinly disguised instances of triumphant feelings, even a stirring of some sexual feelings towards Mrs. Kennedy, which I think were rather rare among adults in their own responses. The children's controls over such fantasies were by and large not so well established as those of healthy adults. However they could not tolerate the massive emotional and prolonged emotional displays which most adults permitted themselves. And that is a steppingstone which I have deliberately introduced to bring you back to our central topic of children's reactions to the death of a parent.

A very similar lack of parallelism, a desynchrony, an out-of-phaseness exists in the reactions of children to the death of a parent, compared with the

reactions of the surviving parent to that same death. The surviving parent's reactions will be intense and long-lasting in many cases. But it will be a rare child who will have either an intense or long-lasting visible reaction within the first few months. I believe that in early adolescence you may see a few examples, probably not so much in mid-adolescence. Again in late adolescence you have seen an adult type of response but by and large weeping will be brief. I might even be concerned about a child who is weeping for half a year every day, hours, because of the death of a parent. I would not be so concerned about an adult who goes through a similar process, particularly for a spouse. Yet as with the Kennedy assassination, what goes on beneath the surface of these phenomena such as weeping, may be another story. I believe the child is handicapped because of his developmental lack, because of his immaturity. He cannot tolerate the emotion of sadness. He cannot be specifically preoccupied with memory of the dead parent. He can't think it through, he can't remember in order to be able to forget. He can't do the work of mourning which Freud describes in his "Mourning and Melancholia" as "a bit by bit working over of the memories of the dead person - in this case the dead parent -" a piece by piece revival of every bit of life that was shared with the lost love object. Unless this can be done thoroughly, intensely, it is probable that the love object will remain all too active in the mental workings of the bereaved child. Let us say that after a year the mother has been able to give up much of her closeness to her dead spouse. At the end of a year she considers herself a citizen once more who is capable of a remarriage, of finding a new father for her family, perhaps of working, of contributing to the community and of fully participating in the care of her children. She is reaching out toward other men. The child whose shallow grief would lead one to feel he was little attached to the dead father, will not reveal that beneath that seeming shallowness was an intense, tenacious attachment which he is by no means ready to surrender. He may fight tooth and nail the mother's efforts to start a new life for herself and him. He will remain loyal to the father of whom he may speak little. His fantasies about that dead father may occupy his mental life, may shape the nature of his conscience. He may try to unwittingly obey the dead father, to do what he feels the father would expect of him, or perhaps in an opposite form to do whatever he feels the now deserted father would not like him to do. In a rebellion against the father who had the inconsiderateness to die and leave him, he may model his life in a negative image of the father's ideals. Thus he still betrays his intense preoccupation with that very man of whom he speaks not, or for whom he wept not or little.

I could go on at length to give you specific data about our work. I really don't think it would be so interesting to you because I think you know it better than I do. I think you have seen individually and as a group more bereaved children than our series of 20 or 25 well studied children has so far brought to our attention for careful scrutiny. Certainly you haven't scrutinized these children from the same points of view, with the same hypotheses, or for the same aims. But what I would like to do is to open the floor to practical discussions, perhaps of some very recent problems that you have come across, things which have puzzled you, situations where you felt some human dilemma, some pastoral dilemma,

some need to clarify your own thinking about the behavior of children and parents in a situation of a recent bereavement. In that way I think we could perhaps make a mutual contribution. I would learn from you and perhaps I could share with you some of our more systematically studied experiences of a parellel sort. Any comments or questions at this point would be welcome.

Clergyman: I wonder if you could and be very brief make those two or three points you made initially for the benefit of those who came in late.

Dr. Kliman: The major points I was making included a statistical argument for the importance of childhood bereavement as a sort of time bomb in the mental lives of children who up to five decades later have an increased incidence of adult life mental illness requiring hospitalization, voluntarily or otherwise, and treatment in private and public facilities. Our statisticians assure us that there is a significant non-random correlation between the loss of a parent and later life mental illness, although it's by no means the only cause of such illness. It is a detectable cause and I hope a cause whose effects could be ameliorated by people in our allied professions. I made the point that the bereavement behavior of children is out of phase, out of synchrony with that of adults and I also tried to emphasize that the earlier the bereavement the more disastrous seem to be its effects particularly in relation to adult life depressions. I wish to alert you to the likelihood that those children who seem to be doing very well but who lost a parent early in life may be far from well in their long range futures and deserve a very close look because they're absolutely unaware in many cases of the burdens which they may be bearing. We now have the responsibility of our knowledge to assume for them.

Pastor Heide: I was wondering - you mentioned one of the things - one of the problems for a youngster was to handle the grieving. Adults can look at it and work at it bit by bit. What can a person do to help a child to handle this? Are you prepared to talk about this - what can you do to try to help them?

Dr. Kliman: I think this is a question which all of you face and so I'd like to take it up, if I may, in a general as well as a specific point of view. I'll come down to very concrete details. I think you're it. Outside of the family, you're it, in terms of what can be done. Very rarely does such a child, outside of a research project, come to a psychiatrist or even to his pediatrician or family doctor for any assistance in this matter. Especially to get such assistance would be uncommon, so you're it. I believe you have to create through education and example a climate in which even the youngest children are permitted to hear and participate in the usual family discussions about what the dead person did, what he was like, who knew him, his accomplishments, and his failings. Such discussions are very frequent, but even more often than not the child is ushered out of the room perhaps puzzled and bitter at not being allowed to participate. I think even a child of two or three ought to be permitted in the room during most parts of your visits to the widow or widower. In your private discussions there probably would be very little that a child would be harmed by hearing and much which would comfort him to know. At least grownups show they have the strength

to talk about what is so very hard for him to talk about. In concrete details I believe you should encourage the participation of children in your church ceremonies which I know you try to do but often meet with the resistance of the families. You'll have to teach me about this. I don't really know. I only have a limited experience compared to yours in numbers. I am told that there is quite a trend for the avoidance of total family participation in the religious ceremonies at the time of death. I think this is a trend which harms the children from a number of points of view. First it prevents them from participating in expressions of grief which are already so difficult and for which they need examples and support. Second, it robs them of opportunities to test the reality of the death, the reality which at early ages, particularly pre-school ages, is a very tenuous reality. The concept of infinity cannot be grasped by a five year old. The concept of permanence and endlessness and the never-returningness to this world of a dead person is really incomprehensible to a child up to age 8. He may say he believes it but he is still waiting for Daddy to come home. John Kennedy Jr. expressed it very well a month ago when visiting one of his father's secretaries in the White House. Although John John had given the salute and had said that a bad man killed his Daddy, late in March during that visit to the secretary, he said, "Where's my Daddy? When is he coming back?" The concept of afterlife I'm sure you know is very difficult to be really clearly comprehended by a pre-nursery school child. The confusions are numberless. The tenuousness is incredible to the adult mind. But certainly when a child sees the body in the box and sees the box lowered into the grave and sees the earth covering over or perhaps even helps in some details of the ceremony, the sense of reality is strengthened. The child then also has a file of memories to which he can later refer to convince himself that the parent really is at least in body underground. Then he need not be afraid that the father is in California off with that woman about whom he heard the year before, his mother angry. He need not be afraid that the father has taken another job, about which the parent may have casually spoken six months before the death, and which the child would prefer to think is the reason for the father's absence. He need not be quite so afraid of the father's body coming back to haunt him. The idea of a spirit and a body in a pre-schooler is not really so easy to distinguish as I believe you would hope it to be, especially in your pre-nursery groups. I hear these confusions among pre-nursery children about the differences between body and soul, so that I think seeing the burial would lay to rest <u>some</u> of the ghost fears which plague bereaved as well as non-bereaved children, but especially those where there actually is a death in the family. Now perhaps you have an even more specific aspect to your question, in which case I would like to take it up.

<u>Pastor Heide:</u> No, not really, Doctor, this was something ....

<u>Clergyman:</u> Do parents add to the fantasy, would you say? In the minds of the children, by saying that "Well, Daddy is not here, he's gone."

<u>Dr. Kliman</u>: I'm afraid so. I think we all bear responsibility for what we do to children in the areas of sexual frankness and frankness perhaps about an even more taboo factor in life, death. It took us a long time to realize how

much children were interested in knowing how babies are made and that they were entitled to a biological knowledge on that subject. I believe that we were trying to protect our adult selves from the curiosities of children by adopting the attitude they should not be told very much, that it was bad for them, but we later began to feel that it might be worse for them not to know than to know some basic facts. We still entertain the idea that children cannot bear to be told facts about death, and often will say with conscious good meaning, "Daddy has gone away." During the war it was not unusual for adults to maintain that a person that had been killed in combat was really simply lost and would later turn up, simply a prisoner of war. Of course occasionally that happened. But where there is even less shred of a hope, you know the sort of stories that are told. I wish you could give me some examples because you probably would know them better than I and perhaps had a family in mind when you asked me that question concerning deception.

Clergyman: Oh, I think this has happened quite a few times, in counsel with a family right after the passing away of a parent, or a grandparent - where the children are in the room there and they are asking questions, "What's he doing here? Why is the Pastor here now? and then they try to shush them up and they endeavor to do it by not giving them the actual fact that this person has died but that "he is on a journey and we want to talk to the Pastor about it".

Dr. Kliman: How old were those children?

Clergyman: Oh, pre-school - pretty young ones because they are pressing for attention at the time when the Pastor is there, asking questions at the very sametime that he is there from the parents, and they sense that there is something wrong because things are so different from what they are and particularly with the Pastor around, you know, everybody - they are sitting around there gloomy and there are tears coming out of course which had been held up for awhile and let out when the Pastor comes. This also seems to upset the child. He wants to know what these tears are all about.

Dr. Kliman: So that perplexity is piled upon perplexity. The child anyway knows somebody has died as the half knowledge of children is almost unavoidable. They know somebody is in the hospital, they know it is serious. They know although nobody is going to tell them, so they are angry because they are not let in on facts. They are perplexed because it seems a vote of no confidence in the child's strength to stand the news. "If Mommy can't tell me what happened, then it must be so terrible that if I found out, something terrible would happen to me." The problem becomes unduly complicated. Here is an opportunity for the practice of preventive pastoral psychiatry. One could inject a note of insistence upon simplifying the children's problems. After all it's too much to expect that the children can deal with both the evasiveness and the loss.

Clergyman: There is the need as you say for education on the part of the parents - preventive education, but I wonder too if we do not get across to our people enough just what eternal life is. They are so griefstricken because they seem to have no hope. Not so much that they feel sorry for themselves but the end seems to be a wall rather than a door for them. Therefore this is communicated

to the children even though the children - I think they can understand more or believe even more than adults in an afterlife. You mention that it's very nebulous to them but children as soon as they hear of an afterlife, I think they seem to take it very easily. They have confidence that you know what you are talking about. This is crushed when parents are not able to face it.

Dr. Kliman: So that one function you perform is really a joint function, that you are a person who can speak with a free mind about death because you have something to offer. You can tell the children, "Yes, Grandpa died, but he is in Heaven. Someday, many years from now, you will join him," and you can convey an attitude of absolute acceptance of the fact of death by means of the adjoining comfort. It is fortunate I think for the child who can have a contact with an unambivalent person at such a moment. I believe that it is the mixed, angry, guilty feelings of the adults which lead them to perpetrate hardships on the children by compounding the child's grief with the perplexity of an evasive parent. I am reminded of a father who consulted me in an urgent fashion with just the very question with which you grappled. It was 24 hours or so after his wife and his boy had been burned to death in a fire which he and his two little girls aged 6 and 5 had survived. As so often happens to the survivor of a disaster, he was ridden with guilty second, third and hundredth thoughts about what he might have done to save his wife and 13 year old boy. What doors might he have kept closed, what electrical circuits might he have shut off to stop this electrical fire, what windows might he have left shut, what words might he have shouted to stimulate his wife to leap from the window when she refused to use it as an exit, how might he have better prepared? He was unable to inform his little girls of the explanation for the very perplexing fact that nobody was speaking to them about their mother and brother whom they knew had been taken by a strange vehicle right in front of their eyes away someplace supposedly to a hospital. It was unspeakable, nobody could say what had happened to them then. I urged him to be frank with the children and explained to him as best I could how he was revealing through his hesitation the self-reproach which he leveled at himself those first 24 hours. When I pointed out to him that it was his hesitation for himself, that what he was afraid the girls might think, he was then able to gether the strength to tell the girls. He became aware that I did not reproach him for his failings, that I did not feel he could have been at all doors, all exits and say all words, and shut off all fuses, in one superhuman, foresightful whirlwind of activity. I think you serve a very similar emergency role in many, perhaps less dramatic, but often equally traumatic deaths. How often you must have heard from a bereaved husband, "Oh, if only I had taken her to another doctor, another hospital, we should have tried another method, another medicine, oh, if only I had sent her more quickly to be examined. Maybe the breast cancer would have been found earlier. Maybe she should have had x-rays." You are in a position to take a reasonable, humane and even, by virtue of your roles, specifically forgiving dispensing function. I feel if this is done properly, vigorously and with some insight on your part as to how serious a burden this is, you will permit the parent to less confusedly deal with the children whom otherwise they were using as pawns to try to protect themselves from facing the facts of what has really happened. They would prefer that somebody be protected against the horror. They

really want to be protected themselves because of the guilt and the loss so they burden the children. It is the same as sexual education. I think that most parents who hesitate to tell their children about the sexual facts of a simple sort are protecting themselves against lifelong discomforts in this area which they don't want to have awakened by a discussion with the children, a discussion which would discomfort them. But it is their responsibility to teach the children the facts of both death and birth. It is unfortunate however that if you undertake this you will be pioneering in the field of exposing children to the facts of death. Many portions of your people, your congregations, your parishes will be quite adverse to this sort of education and exposure.

Clergyman: Can you elaborate more on your statements to the effect that the well adjusted child might take a death in his stride, while to the other one who is not adjusted, the death might be only the indication that might bring out the illness.

Dr. Kliman: My suspicion, unproven, is that even well adjusted children who suffer a parental loss early in life may succumb to that stress, so I wouldn't agree with the phrasing of your question. I believe we are dealing with something like a dose of tuberculosis. There is an insult to the organ of the lung - a few hundred tuberculosis germs in a healthy lung may well be encapsulated. The person will go all his life with just a little calcium encircling those tubercule bacilli, and will not get the disease. A sickly person or a child exposed to the same number of tubercule bacilli may develop a raging, fatal tuberculous pneumonia. But even the most healthy youngster or adult exposed to 100,000 tubercule bacilli would succumb. It is not a straightforward problem when a child is bereaved. If a child of age 2 experiences the death of a mother, it might survive and be well. But I would have more question concerning a child aged 6 months who is being breast fed. The simultaneous weaning from the breast and the loss of the mother forever might lead to easily detectable and insurmountable pathology in that child. I don't know yet. I would say that even the healthiest of children would probably be burdened by that combination of circumstances, but I don't know. That's what we are trying to predict, not to look backwards from 30 years later, when the facts are obscure.

Let's take the instance of a well boy on whom I do have an 18 year follow-up. He was well at age 5. His father was not well. His father took a knife and came into the bedroom. The child was on a cot. The mother was in a bed which the father had been sharing. The father stabbed the mother in the chest. The child woke up whereupon the father stabbed the child in the chest, stabbed himself and leaped out the window to his death. Both the mother and child survived the multiple stab wounds. The mother, a sensitive and intelligent woman, was astonished at the lack of distress displayed by this 5 year old boy who had been attached to his father. She took him to a psychiatrist, an eminent psychiatrist experienced with children, but not having the benefit of the statistics to which I referred today. The psychiatrist felt the boy was doing quite well and saw no pathology as probably I also would not have seen any pathology. Fourteen years later the boy was overtly schizophrenic at a time of what we might call an oedipal triumph - triumph in the sense of having achieved something in competition with his father. He happened to be extremely successful in the junior year of college. After a splendid success in his final examinations which were symbolically a competition with his intellectual father, he developed paranoid delusions and made a suicidal attempt. This suggested a further identification and attempt with reunion with his father. The boy has done quite well. Dr. Wilder knows this boy. He gives me an occasional follow-up. But the well child was not well 14 years later.

Father Cassidy: Wasn't he always schizophrenic?

Dr. Kliman: Well, Father Cassidy, it isn't always that a child gets to be examined so that we can say that he appeared to have good mental functioning. Schizophrenia at age 5 is a quite striking disorder. So that I would be safe in saying that at that age he was not evidently schizophrenic.

Clergyman: Dr. Bender feels it can really be detected at a few months of age.

Dr. Kliman: If it's present. You see, but he was examined and it was not found. The doctor in question is familiar with Dr. Bender's work. It's possible that he missed the boat.

Clergyman: Yes, and I think it's very possible that maybe sometimes this doesn't show.

Dr. Kliman: To beg that question, we've put it in the form of a hypothesis. Let us say that if these are simply children who would become schizophrenic anyway then the incidence of schizophrenia should be about the same in bereaved children as in the general population.

Clergyman: I have another question. Tell us doesn't it make a difference between the children if the parents are schizophrenic?

Dr. Kliman: Very good point. We would have to go further and we would say that the incidence of schizophrenia in the family of a schizophrenic father would have to be increased. Fortunately we could begin to make that kind of comparison. In our study we hope someday that we could take into account these multiple variables. In fact we could ideally be so careful in our study of families that we would have a separate group where we had manifest pathology in the parents. We would make a much different kind of prediction for such children. Certainly it is a distinct handicap to have emotionally ill parents.

Clergyman: When this connection was made with the death of the father and the behavior 14 years later of this young man, it reminded me of another case with death of a mother. When I saw her, her daughter was 20 years old. - The girl had very unusual sexual behavior - she was a prostitute. It was because the father been telling her she caused the death of her mother. She thought the only way she could repair the damage done was by losing the thing dearest to her, her honor, so she gave herself up to anybody for nothing.

Dr. Kliman: This leads me into another burden suffered by bereaved children. I wouldn't be so sure that her rationalized explanation-intellectual theory she gives of her prostitution is very much to the point. I would look more to the general behavior of a parent with a child of the opposite sex. The mother has died and the now adolescent girl is with a still fairly young father. They are both unaware of the burdens which this situation places upon them. They are not going to commit incest. It would be very rare, especially in a devout family.

Clergyman: She was not a Catholic and the time I saw her was in an institution. The mother had died when she was 3 years old and the father had been beating it into her head that she was the cause of her mother's death.

Dr. Kliman: I can't speak intelligently about that case, but can tell you that this is not an uncommon event. Promiscuity and even burdensome incestuous feelings towards the surviving parent are really a terrible problem for bereaved adolesccents. I know a girl who is much better organized than the one you tell me about, but lost her mother when she was 16. Within a few months she was walking around in front of her father quite scantily clad and trying to fool herself into thinking this didn't mean anything and didn't bother the father, didn't bother her. She went on to many fantasies of having intercourse with married men. Fortunately she didn't carry out the ideas. She was already in treatment. The burden with which she struggled was the loss of a controlling influence. The mother's presence had kept down what ought to be kept down - the unconscous incestuous wishes of early childhood. That influence was not present. It could be supplied by religion or by the community, but also preferably a parent who takes the place of the dead parent. Of course the guilt about such a desire for physical intimacy with the surviving parent is a terrible guilt. The child is liable to hold herself responsible for the death of the parent. What an advantage from the death - after all now she has her father to herself. It was only natural she would want her mother out of the way so that she can enjoy the father more. In a more seemingly innocent way one of the most uniform phenomenon which we observe is that children are getting into bed with the surviving parent. It happens all the time anyway, but it happens much more in bereaved families. They are getting into bed with a variety of excuses - the little child of 4, the not so little child of 8 - the big girl, the big boy of 11, 12, gets into bed with the parent of the same or the opposite sex on the ground of loneliness - on the ground of not being able to sleep - on the ground of being afraid of the ghost of the departed - on the ground of being sad. On whatever ground it is a heavy burden for the parent and the child to be having this unaccustomed physical intimacy. The unconscious gratifications lead children and parents to feel guilty (they know not why). They don't have incest - they just have guilt. They have what adolescents would call "the blame without playing the game". They are not really doing anything immoral but they bear the guilt for it anyway because they have put themselves or fate has put them into the position of being unduly intimate with the surviving parent.

One of the biggest educational jobs I see is encouraging some separateness - some individual activities of surviving parent and child. They should not suffer the burdens of an undue intimacy. You can help them to organize their activities in a more wholesome way, and even to pay a little attention to what they do at the end of the day, how they arrange their sleeping quarters even, I think. I imagine it would be difficult for you to inquire in this direction but probably in your visits to the home you may notice that the beds have been switched around and might thus have an opportunity to comment in a bland way that this presents a burden. I am amazed at how uniformly this occurs - this bedswitching.

Clergyman: Is this true for both the parent and the child of the same sex - and the opposite sex?

Dr. Kliman: Yes, it seems to have no distinction and of course it is no advantage for a boy to be sleeping with his father. That is not so wonderful either. The parents will be amazed - if they are already sleeping with a child - and you say that it might not be wholesome. They are not going to take kindly to any suggestion you would make that this would be unwholesome for a sexual reason. I would strongly

advise you not to speak in such terms regardless of how convinced you might be of it. I would speak in terms of the necessity for independence of a bereaved child. He must learn to be "an individual in his own right, including to sleep as an individual". I wouldn't go a step beyond that, but to be very firm.

Clergyman: The same principle is involved with the brothers and sisters?

Dr. Kliman: I believe so. And probably with less control over the behavior there. Of course you can usually rely on a parent to be rather circumspect in his physical behavior with a child. You can't rely on brothers and sisters, no matter how well behaved they may be in the day time.

Clergyman: Would you say it is more common for brothers and sisters to sleep together? How does the parent select a child to sleep with?

Dr. Kliman: I don't know just how much this varies from culture to culture - group to group. I think Mrs. Kliman ought to tell us about Diana, who sleeps with the father, because there is a case where the choice can be understood a bit. The choice is in terms of the child identifying with the lost parent and the parent sharing this sense that the child was in fact like the mother that died. Would you tell us about that?

Mrs. Kliman: This was a case of a mother who died of breast cancer. There were four children in the family, 3 boys ages 12, 9 and 7, and a little girl aged 4. The children all knew that the mother was dying. She had been hospitalized for I believe a month prior to the actual death. When the father came home and announced to the children that the mother had died, the little girl jumped up and said, "Don't be sad, Daddy, I'll be a Mommy soon myself". - Within a day or two she took increased interest in several of the mother's hobbies in a very dramatic way. The mother had been an interior designer, an architect and an artist. The child started drawing - something she had no particularly strong interest in previously. She wanted to take over the cooking which she remembered the mother had done months before. At no time did the child say she was sad or missed her Mommy. She did not cry. She soon got into the father's bed, every single night. The sleeping pattern was soon established that this child would sleep with Daddy and the three boys would sleep in their own bedroom. I don't think it's always this simple, though. In other families that I have seen where there have been a number of children, there does not seem to be a selection of either oldest or youngest or middle or opposite sex or same sex. Occasionally there is an alternating where the father will sleep with one child one night and another child another night.

Dr. Kliman: Well, I'd like to end on an encouraging note. I have emphasized the sickness inducing consequences and the hazards of bereavement. But you noticed that Diana , of whom you just spoke, took a constructive line, competitive though it was with the dead mother. Diana rose to the occasion by developing a constructive hobby of drawing. It would help her to continue this successful sublimation of her closeness to the mother through the hobby. She could become an individual who does not have to sleep with father. We could

help the father to be stronger and not to take advantage of the little girl as company for him, which we know is hard for him to give up. We might see a very strong individual emerge from this tragedy

Clergyman: You pointed out that the younger the child the worse the effects and if the mother died it would effect the child very much. Is it true that the father is not so much a concern for the child at this stage of life?

Dr. Kliman: I believe this idea of yours holds up very well when examined in the light of statistics. The death of a mother by and large is much more fateful for a child. The death of a mother to a girl is more fateful than for a boy. I would not like to speculate on all the reasons for that but take it as a fact for the present. The death of a father seems to be generally a hardship for boys in adolescence, but also for girls in adolescence. The statistics are more clear concerning the connection between adult life depression and death of a father for a boy in adolesence. Thus, I would take a close look at a boy whose father died when he was a teenager. That boy might be headed for a depression as little as 10 or 15 years later.

Clergyman: What might happen with death of a father during a child's infancy?

Dr. Kliman: In the very early stages of life I think the main criterion would be the effect upon the mother. If the mother would become withdrawn in a prolonged depression as a result of her bereavement, she might be unable to respond to the child's signals for affection. She might not even feed the child properly if she is very depressed. The death of a father could be in a way the death of the mother for a year or so.

Clergyman: Let's suppose the child loses its father or mother and is now an adult, and you say the incidence involved among these people is much higher. What can you do to help them at this point? I suppose they are not all obviously ill mentally. but we should try to prevent this sort of thing

Dr. Kliman: My suggestion would be first of all to be very attentive to such a person when he comes to you. When he comes to you he may be really trying to use you as a stepping stone for psychiatric treatment or he may be trying to use you as a parent substitute even though married by now. You might think him well set with all sorts of gratifications. He may be and should be allowed to lean on you a little more than the average person. I don't feel especially qualified to answer that question anymore than any other psychiatrist, because I am trying to address myself to the preventive possibilities. I feel it is rather difficult to treat bereaved people in adult life so that it is even more important to do the preventive work. The studies of psychoanalysis of bereaved people show that it takes often a couple of years before a relationship of the doctor can be established to the point where the trust in the doctor suffices for really useful treatment. Apparently there is disillusion with the helping figure of the dead parent. The parent abandoning the child through death makes it very difficult for the grown up child to trust anybody else in a really deep way.

Clergyman: Do these children have nervous breakdowns that follow any patterns in their personality?

Dr. Kliman: There are some patterns in timing of breakdowns. They show some tendency to cluster around anniversaries of the death of the parent. They also tend to cluster in married people at a certain conjunction of timings as follows: a mother lost her mother when she was 5. She has children. One of the children is now growing up and is getting to be 5 years old. For reasons that the mother has no idea of, as this child gets closer and closer to the age at which she was when her parent died, she starts to get depressed. This again is a very important anniversary. The types of illness tend to cluster in a depressive category. Serious depressions are more frequent. However there is a tendency for all types of psychiatric illness to be more frequent among bereaved people. In childhood where you see the consequences occurring rapidly, it's my impression that anti-social activity is prominent. Stealing seems to be a symbolic way of getting some good from the world. The child who has lost a person tries to steal a thing. In the history of juvenile delinquents, perhaps for many other reasons as well, bereavement is significantly more frequent than in the general population of children.

Clergyman: What about children who have lost a parent through separation or divorce, not actually death?

Dr. Kliman: The situation there is very cloudy but strikes me as in many respects simply not so dramatic, not so easy to distinguish the consequences. The loss is often a very cloudy loss. It is a coming and going kind of loss. The parent is often still available on weekends. The parent may in some cases be creating a greater burden through the divorce than through the death, particularly if the child has reason to be hostile towards one of the parents. However it really is - one cannot make a clear cut comparison because of the complexity of the two situations.

Clergyman: How would the social background and/or the I.Q. and/or the economic situation of a bereaved child, how would that change the statistical picture?

Dr. Kliman: The statistics have been somewhat controlled for those factors. Consequences of bereavement appear to cut across class and economic lines according to standard criteria that sociologists use. However it is my impression there is a marked handicap for a child bereaved in a low economic class family. It is very hard for a father to maintain the household intact if there is no family at large to fill in. He may have to get a strange person to help him. He may not be able to afford it. He may have to give the child out to another branch of the family in a different city or to a community resource. These changes geometrically expand the problems of the child as he adapts to a new environment and new love objects.

There is tremendous opportunity for preventive work in providing homemakers and housekeepers to keep the family intact. It is being done but it is not being done enough. I don't think we train our homemakers to be sensitive to the needs of bereaved children or educate them to the difficulties that such children have in accepting a substitute for their mother.

Dr. Kliman: I would still like to close on a positive note and to ask you to think over how many constructive, successful, well adapted people you know have been bereaved early in life. Some have really made capital of their tragedy. I'd like you to think of the wife of a clergyman, Harriet Beecher Stowe, whose mother died when she was 2. Her mother had been a clergywoman. Harriet Beecher Stowe hardly knew her mother and hardly remembered her by the time that she was grown. But very early she determined that her way of remembering her mother was to be her mother. She identified with every moral and industrious precept her mother had provided and which family legends continued for her. With that model inside her, Harriet Beecher Stowe became an enourmously productive, socially active person. She wrote many books, founded many schools, and became her mother in a real sense. Apparently it worked. The process of identification which is so interesting to those of us who are analytically oriented, is a process which apparently can go on to the advantage of the child. It has to go on in a relatively safe atmosphere. It is our job to keep the burdens of the child down to such a low level that the constructive activities can continue, that the biological capacities, the psychological growth capacity can be maintained. I think you are men who could help us do it.

I got a note saying that I should consider asking you to refer us children for our study. I had that in mind. I would like you to think about those people to whom you already extended a helping hand. We would be very grateful to you if you would let us know about families where there has been a death within a few months. We would like to talk to the surviving parent. We have a number of questions we'd like to ask about the child and parent and how they are getting along. We think bereaved people who would participate by letting us talk to them would be doing a good turn for others. They would help us understand what a bereaved family is up against, so that someday soon we can begin helping better. Thank you very much for your attention and for your questions.

Clergyman: Will you tell them, Dr. Kliman, where they can reach you and make this referral. It would probably be better if you saw them direct.

Dr. Kliman: Yes, you can reach us right here through Dr. Zwerling's secretary. The number here is TY. 2-6000. We're interested in children even who are infants because we want to talk to the mother or father, and up to age 19. I would like to tell you that even though we offer no therapy at this time we certainly plan to. We don't offer any at this time. Yet it has been our uniform impression that the most reluctant, most resistant cooperators in this study have thanked us for the chance to talk a few hours about what they find very difficult to talk about to other people. It is hard for a bereaved man or woman to talk with his own family about what he is feeling. He doesn't want to get them stirred up. He doesn't want to be stirred up by them. But he welcomes the opportunity to talk to someone whom he knows will not respond with disturbing personal emotion. Thank you.